THE STATE OF NEW HAMPSHIRE

DEPARTMENT OF LABOR

CONCORD, NH 03301

REPORT OF EXTENDED DISABILITY

This form shall be completed by the Insurer or Self-Insurer and filed with the Department on every case where total disability benefits are anticipated to or have continued for six months as required by Administrative Rule Lab 509.03 in accordance with RSA 281-A:25.

Claimant_____ S.S. No._____
(First Name) (Middle Initial) (Last name)

Address_____
(No.) (Street/P.O. Box or RFD No.) (City/Town) (State) (Zip Code)

Telephone Number_____
(Area) (Number)

Check (√): Male ☐ Female ☐ Age_____

Education, Circle Highest: 1 2 3 4 5 6 7 8 9 10 11 12 1 2 3 4
(Primary) (Secondary) (College)

Injury Date_____ Disability Date_____
(Mo.) (Day) (Year) (Mo.) (Day) (Year)

Nature and Location of Injury_____

_____

_____

Employer's Name_____

Office Address_____
(No.) (Street/P.O. Box or RFD No.) (City/Town) (State) (Zip Code)

Telephone Number_____ Employer's I.D. #_____

Carrier Name_____ Carrier #_____

Address_____

Date employer was contacted as to claimant's return to employment_____

Employer's response: Yes ☐ No ☐ _____
(Name of Person Contacted)

If yes, in what capacity_____

_____ _____
(Date) (Carrier Representative's Signature)

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